Ruth Cureton considers the relationship between abuse and dissociation

Dissociative Identity DISORDER

key points

Severe trauma and abuse in childhood can lead to dissociative identity disorders in adult life. Unpleasant memories are parcelled away some distance from consciousness, but flashbacks to unrecognisable, terrifying episodes may disturb and overwhelm a survivor's awareness of self, time, place and person.

Suzie (name changed) went through such experiences, while managing to maintain a front as GP, wife, mother, and house group leader. Two different evangelical churches were unhelpful. The author describes best practice in healthcare and the church.

Case History

Suzie (name changed) is now a GP, and has given consent for this case history to be published. Her childhood was affected by neglect of her fundamental attachment needs because of physical and psychotic illness in both parents; by the trauma of witnessing domestic violence as her mother and brothers were subjected to chronic verbal and physical abuse; and by sexual abuse at the hands of her father. Without a protective attachment figure, she then fell victim to paedophiles within her small community.

Despite all this she attended medical school, became a Christian through CMF students, married a Christian, completed postgraduate training, and worked part time for 20 years, while bringing up a family.

During these years Suzie searched for support in an evangelical church context and was told:

- forgive all perpetrators lest you be judged
- honour your father and mother regardless
- the old has passed away and the new has come
- move on and live in the fullness of your new life

Having survived childhood by role-play and dissociation, she role-played good Christian wife, mother, doctor and house group leader. She pressed on through chronic anxiety, recurrent depressive episodes and various other symptoms.

She neglected her own needs, and allowed herself to be traumatised and spiritually abused as, by now in a charismatic church, her symptoms were attributed to demonic activity. Eventually family bereavement and church and work crises combined to cause major depressive breakdown and psychiatric admission. So began a long journey to recovery through appropriate medication and talking therapies.

Dissociative Identity Disorders (DID)
Diagnostic codes:
ICD 10: F44.9 Dissociative Disorder (unspecified)
DSM IV: 300.15 Dissociative Disorder NOS

The ongoing negative effects of neglect, trauma and abuse can impinge on us from all sides: from patients, staff, colleagues, family, friends and fellow church members. We are expected to understand, advise, support prayerfully, and treat, but our dearth of training and experience may leave us feeling inadequate.

Child abuse is sadly widespread. In one extensive survey of the childhood experiences of 2,869 18-24 year olds, 13% of the respondents assessed themselves as having been abused[1]. Elements of neglect, trauma and abuse frequently appear in the backgrounds of those suffering from psychotic

illnesses, bipolar and personality disorders, neuroses, phobias, obsessive-compulsive disorder, eating disorders, post-traumatic stress, and somatisation disorders.

Less familiar are the dissociative disorders. These are a series of, I believe, God-given coping mechanisms available in childhood whereby a combination of physiology, creativity and a child's innate spiritual awareness allows a child to tolerate the intolerable and survive the catastrophic.

For example, when rendered powerless and voiceless during sexual abuse some children are able to 'escape' in their imagination, perhaps to a sunny glade or other safe place, until the episode is over. The actual experience is then 'parcelled' away, at some distance from consciousness. Recent developments in neurobiological research are providing a physiological basis for these phenomena [2].

Where abuse is severe and repeated, and particularly if a primary attachment figure is either absent or is the cause of the trauma, then the areas of memory and narrative unavailable to normal consciousness may be widespread, with whole stages of normal childhood development being hindered in some cases [3]. The earlier in life that deprivation, trauma and abuse begin, the more widespread the consequences are likely to be. But the child survives and may function relatively normally at school and go on to achieve well, as the case history shows.

However, the unresolved trauma remains imprinted in both body and psyche and, as occurs in post traumatic stress disorder (PTSD), certain triggers such as a visual image, smell, symbol, word, phrase or situation can make a sudden, unexpected and often extremely unpleasant connection between the past trauma and present consciousness. Such traumatic flashbacks to a known occurrence in adulthood can be severe and disabling. Flashbacks to an unrecognisable, terrifying episode of child abuse may disturb a survivor's awareness of self, time, place and person to an overwhelming and destabilising degree. To the outside observer or confidante these episodes can appear or sound bizarre.

For both sufferer and significant others the boundary between sanity and madness may seem dangerously close, though not crossed. Although some degree of dissociative symptomatology may occur in many other psychiatric conditions, if DID is the primary underlying condition it can be treated very effectively. However, survivors with DID spend an average of 11.9 years in secondary care before being accurately diagnosed, and treatment is then complicated by the added traumas of the intervening years [4].

How can Christian doctors help?

I have had to recognise the limitations of both my medical and Christian training and accept that bizarre-sounding symptoms and behaviours may be neither factitious, nor signs of psychosis or personality disorder, nor indicate demonic activity. They may simply be outside my range of experience and understanding.

Many survivors of neglect, trauma and abuse are neither 'mad' nor 'bad', but just extremely 'sad' that, having been powerless and voiceless during their suffering, they have yet to be heard and offered appropriate help. They deserve thorough expert assessment, diagnosis and treatment, though NHS resources here are poor.

In healthcare

Investigate your local personnel and resources, statutory and voluntary, specifically targeted at PTSD, complex PTSD and DID. Sadly, due to the extent and nature of the help needed, short courses of practice-based counselling may only serve to emphasise the complexity of the survivor's problems without offering hope of a solution.

In the churches

Often looked to by survivors as a source of safety and comfort, churches need further guidance and training in a wide range of mental health issues. First, they must do no further harm. Second, they can input consistently, patiently, sensitively, and with appropriate boundaries to build the survivor's self-esteem. This will gradually allow them to form trusting relationships without placing undue demands and expectations on them, which they may try to meet to the detriment of their own faith, health and well-being.

Churches must be particularly sensitive when the abuse occurred in a religious context, and beware applying scriptural exhortations without considering the survivor's own journey and understanding. Many children abused by their own parents blame themselves. In a young child's developing psyche it is actually safer for them to see themselves as bad than to live with the knowledge that their 'God-like' protectors and providers are bad or unsafe. Many survivors need support to acknowledge both parental culpability, and the appropriate righteous anger that follows, before forgiveness can realistically be approached.

Conclusion

Listening, accepting, validating and arranging appropriate treatment for survivors, in an open-minded and non-judgmental way, can encourage them forward on their extremely challenging journey. Suzie, a real life case, is now moving towards full health and wholeness.

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further reading

- Mind (National Association for Mental Health). *Understanding Dissociative Disorders*. 2003. Can be ordered from Mind on 0845 766 0163 or read on the web at: *www.mind.org.uk/Information/Booklets/Understanding/Understanding+dissociative+disorders.htm*
- Marlene Steinburg. *The Stranger in the Mirror*. Harper Collins. 2001. ISBN-10: 0060954876 ISBN-13: 978-0060954871
- Beer M D, Pocock N D (Eds). *Mad, Bad or Sad?* Christian Medical Fellowship, London. 2006. ISBN 978-0906747353

references

1 Cawson P *et al*. Child maltreatment in the United Kingdom: a study of the prevalence of child abuse and neglect. London: NSPCC, 2000. ISBN: 1842280066
Madge, Nicola. Abuse and survival: a fact file. London: Prince's Trust - Action, 1997. ISBN: 1902243005 Can be read at: *www.nspcc.org.uk/Inform/Home/InformHomepage_ifega26884.html*

2. Mellers J. Diagnosis and management of dissociative seizures. Department of Neuropsychiatry, Maudsley Hospital, London. September 2005 *www.e-epilepsy.org.uk/pages/articles/show_article.cfm?id=48*

3. Steele K et al. Dependency in the Treatment of Complex Posttraumatic Stress Disorder and Dissociative Disorders. *The Journal of Trauma and Dissociation* 2001; 2 (4): 79-116.

4. Guidelines for Treating Dissociative Identity Disorder in Adults. European Society for the Study of Trauma and Dissociation, and the UK Society for the Study of Dissociation. 2005 *www.issd.org/indexpage/treatguide1.htm*